Client Information Form

Anna Orcutt, MEd, LPC, NCC

Client Information

First Name: ______________________ Middle Name: ___________________ Last Name: __________________________

Address: ____ City: __________________ State: ______ Zip: __________

Home Phone #: ___________________ Cell Phone #: ______________________ Work Phone #: __________________

Employer: _________________________ Social Security #: __________________ Marital Status: ___________________

Birth Date: ______________ Age: ____ Gender: _______ Email address: ____

Responsible Party Information

Responsible Party is Patient: Yes No

First Name: _______________________ Last Name: _____________________ Relationship to Patient: _______________

Address: ____

City: _________________________ County: ______________________ State: _________________ Zip: ___________

Home Phone #: _______________________________ Work Phone #: _____________________________

Financial and Policy Holder Information

Primary Insurance:

Insurance Company: ___________________________ Contract #: ____________________ Group #: ______________

Effective Date: __________________ Policy Holder Name: ____

Policy Holder SS#: ___________________ Birth Date: ____________ Relationship to Patient: ______________________

Policy Holder Address: _____________________________________ City, State & Zip: __________________________

Policy Holder Telephone #: __________________________ Insurance Telephone #: ___________________ Sex: M or F

Secondary Insurance: Yes No

Insurance Company: ___________________________ Contract #: ____________________ Group #: ______________

Effective Date: __________________ Policy Holder Name: ____

Policy Holder SS#: ___________________ Birth Date: ____________ Relationship to Patient: ______________________

Policy Holder Address: _____________________________________ City, State & Zip: __________________________

Policy Holder Telephone #: __________________________ Insurance Telephone #: ___________________ Sex: M or F

* See attached “Counseling Consent” for more information about third-party payers.

I acknowledge that I have read this form and understand its purpose and content.

____ _____________________

Client (or authorized Representative/Relationship to Client) Date